TESTIMONY OF
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ON
STRENGTHENING AND IMPROVING THE MEDICARE PROGRAM
BEFORE THE
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Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to discuss strengthening and improving the Medicare program. President Bush believes Medicare is the binding commitment of our society to our most vulnerable citizens and that this commitment to the American people should be kept. To this end, the President is urging Congress to provide more choices and better benefits to Medicare beneficiaries bringing Medicare into the 21st Century. In strengthening and improving what is now a $277 billion program, we need to combine what we know are the strengths of the Medicare program with the best of the current private health insurance market and the Federal government's experience in running the largest employer-sponsored health insurance program. As successful as the Medicare program has been, it has not kept pace with decades of dramatic improvements in health care. As a result, Medicare beneficiaries today lack many of the options and benefit coverage available to millions of other Americans.

When it was created in 1965, Medicare was modeled after the Blue Cross and Blue Shield coverage existing at that time when health care didn't offer preventive care or catastrophic care and usually did not include a prescription drug benefit. Times and Blue Cross plans have changed, but Medicare has not changed with them. Not only must Medicare include the benefits we have all come to expect, but we should give Medicare beneficiaries the same options that Americans under age 65 enjoy. If we were creating the Medicare program today, we would model it after what consumers are receiving in today's health care marketplace: more choices and better benefits. Enrollees can now receive care at reduced cost from networks of preferred providers and obtain prescription drug coverage.

Medicare, as a national program with payment practices and provider participation rules determined mainly by statute, does not negotiate rates, but fixes prices to all providers, regardless of price, volume, or quality. Whether, and on what basis to treat providers differently is a complicated issue that often requires an intimate knowledge of local market conditions. A national program cannot make these local market-level distinctions, which is another reason Medicare needs improvement.

The opportunity to make these changes to strengthen and improve Medicare is now. With health care costs rising and the Baby Boom generation nearing retirement, Medicare faces serious long-term financial challenges. According to the most recent Medicare Trustees report, the cost of care continues to increase. For example, Medicare expenditures for inpatient hospital care increased by almost 10 percent in 2002 and Medicare Part B spending increased by over 9 percent; home health went up about 8 percent. Not only is it important to offer modern, innovative health care choices for seniors, but to do so in a way that is fiscally responsible.

We must update the program's structure to make the best use of our modern health care delivery methods to maximize the benefits for current and future participants including access to prescription drug coverage. The President has committed up to $400 billion over the next ten years in his FY 2004 budget to pay for strengthening and improving Medicare, and has offered a framework that will give all Medicare beneficiaries access to:

- **Prescription drug coverage** that enables seniors and people with disabilities to get the medicines they need;
- **More choices of more health care plans –** just like Members of Congress and other federal employees enjoy today through the FEHBP;
- **Continued choice of doctors and hospitals** for the treatment and care they need;
- **No cost-sharing for preventive services** such as screenings for cancer, diabetes and osteoporosis; and,
- **Protection from high out-of-pocket costs** – Often available in plans, but not available to Medicare beneficiaries.

THE IMPACT OF PPOs

One option that achieves these principles are Preferred Provider Organizations (PPOs). PPOs are a growing form of health insurance and are now the most popular type of coverage in the private insurance market, covering 52 percent of the employer group market today. Together with the very similar Point of Service (POS) model that covers 18 percent of enrollees, 70 percent of insured Americans are in these "hybrid" plans. In contrast, traditional fee-for-service (FFS) plans represent only 5 percent of the private insurance market; however 87 percent of Medicare enrollees are in traditional FFS.

PPOs give beneficiaries a wide choice of providers, allowing them to stay within the PPO network for maximum cost savings or go outside the network to any doctor or hospital, if they desire. Moreover, they may include greater coverage of preventive care services as well as better coordination of health care services. Additionally, the PPO design is flexible enough to work well in both cities and rural areas. In particular, the vast majority of hospitals operating in rural counties—including counties where there is only one hospital—have Blue Cross contracts that are almost always part of a PPO, according to a May 2003 report by CMS' actuary.

Applying the principles outlined in the President's Framework, CMS' actuaries estimated that the average cost in competitive private plans, including PPOs, would be less over the 10-year period than the corresponding cost in traditional Medicare. These savings are expected to grow over time, primarily because beneficiaries enrolling in PPOs would have the option to switch to less expensive plans to reduce their monthly premiums, and because the cost growth rates for PPOs are expected to be slightly less, on average, than increases in Medicare fee-for-service costs.

Our actuaries' estimate was derived from data that PPOs provided regarding CMS' PPO demonstration**.** These data suggest that the most efficient plans have the potential to deliver the same benefits for an average of 2.3 percent less than the cost of fee-for-service Medicare. PPO-style health plans have the potential to control costs as well as or slightly better than traditional Medicare over time; however, any potential savings or costs strongly depend on the proposal itself. For example, the potential for savings in Medicare depends greatly on whether:

- Beneficiaries are given the option to choose the most efficient plans and save money on their premiums;
- The bidding process accepts only a limited number of PPOs per region, so that plans bid aggressively and capture a large market share within that region; and,
- The contracts contain a risk-sharing arrangement, whereby the plans and the government share in any savings or cost overruns beyond specified levels.

The private marketplace has developed an efficient and effective model of health plan that meets the needs of enrollees and purchasers as well as providers, in specific local markets. Likewise, the President's framework utilizes the PPO model in order to:

- Cover a wide geographic area, giving those in rural areas new options;
- Offer enrollees a choice of providers at a reasonable cost;
- Include drug coverage;
- Engage providers in quality improvement activities
- Engage enrollees in activities to improve quality such as disease management; and
- Encourage providing innovative benefits to enrollees, such as health education and smoking cessation.

The President's proposed model would rely on regional PPO health plans and have the same types of features. What consumers value most – options – would be the hallmark of the proposed Medicare model. Beneficiaries would be able to choose among the current traditional fee-for-service Medicare, the new enhanced fee-for-service/PPO with an enhanced benefit package, as well as MedicareAdvantage, with a tighter network for greater savings.

CONCLUSION

The President's approach for Medicare reform was designed to gradually incorporate the benefits of competition in the provision of Medicare health services. Today all doctors, hospitals, and health providers are paid federally fixed prices for their services. Injecting a modest incentive for performance based on price and quality will lower cost, improve quality, and enhance the performance of Medicare for many beneficiaries. The current health care

market has evolved by responding to individuals' desires for provider choice, providing access to state-of-the art treatment, and offering high quality care. The President's plan is based on combining the best of Medicare – a community-rated social insurance health plan – with the option chosen by approximately 130 million Americans, the flexible PPO benefit model. Improvements to Medicare, however, should not force changes on today's seniors who are satisfied with the current system. They must be able to keep exactly what they have. But seniors who want more benefit options should be able to select better plans – or keep the one they were happy with at age 64.

We want to work together with you to enact significant Medicare legislation this year, and we are encouraged by the bipartisan progress that is already being made. America's seniors and people with disabilities need a drug benefit, and they need modern benefit options in Medicare. America needs a 21st century Medicare plan that provides better coverage, including access to prescription drugs. This is the year to get it done. Thank you for the opportunity to discuss this very important topic with you today. I hope that I have been able to express the Administration's dedication to strengthening Medicare as well as our commitment to work with you to do so. I look forward to answering your questions.